

## **Arkansas Insurance Department**

Form AID-CS-Provider (04/20)	)
INV	
Tracking #	

## HEALTH CARE PROVIDER COMPLAINT FORM

	1 HEALTH CARE PROVIDER INFORMATION  Name	Phone: 501-371-2640 or 800-852-5494
Policy No Group/Plan Number	Patient's Name	
Release of Information: My signature on this form constitutes my authorization for the Arkansas Insurance Department to ob ny information or documentation from any legal entity it deems necessary for the resolution of my complaint/inquiry. A photoc	3 Explain below the problem you are experiencing. Also, please a	
ny information or documentation from any legal entity it deems necessary for the resolution of my complaint/inquiry. A photoc		
ny information or documentation from any legal entity it deems necessary for the resolution of my complaint/inquiry. A photoc		
ny information or documentation from any legal entity it deems necessary for the resolution of my complaint/inquiry. A photoc		
of this form will be considered valid authorization.		